CERTIFICATE OF MEDICAL NECESSITY

DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 789 (3-2006)

Clear Fields

TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR (TENS)

SECTION A - Certification Type/Date:

Date	☐ Initial ☐ Revised
Name	Patient ID

SECTION B - Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME)

1. What is the type of pain and the location of the pain?

2. Describe the pain and the length of time your patient has been experiencing the pain.

3. What types of medications and therapies have been previously tried and have failed?

4. Medicaid requires a 30 day trial period. The patient must be re-evaluated at the end of the trial period. Please provide the following dates: Trial Began, Trial Ended, and Re-evaluation Date.

Date Trial Began:	Date Trial Ended:
Re-evaluation Date:	

5. Number of Leads: ☐ 2 ☐ 4	6. Do you want your patient to purchase the device? ☐ Yes ☐ No

7. If no, how many months do you recommend rental of the TENS?

SECTION C Physician Signature/Date

Signature	Date	(Signature and Date Stamps are not acceptable)